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IN THE

Supreme Court of the United States

OCTOBER TERM, 1942.

No. 878.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA, a corporation, *Petitioner*,

v.

JANE SAIS, *Respondent*.

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI.

[redacted]

SUBJECT INDEX

Page

Statement of the Case 1

Argument 6

The Petitioner's argument is based on the false premise that the truth and materiality of insured's representations were not in issue and the Petitioner failed to meet its burden of proof on these issues 6

As to Point A of Petitioner's brief, Petitioner had ample notice and opportunity to meet the issues 7

As to Point B of Petitioner's brief, the holding of the Court of Appeals was that Petitioner on the evidence had failed to meet the burden of proving the falsity and materiality of insured's representations 9

As to Point C of Petitioner's brief, the Petitioner misconstrued the Court of Appeal's opinion... 11

As to Point D of Petitioner's brief, the Court's decision was in full accord with decisions of this Court 12

As to Point E of Petitioner's brief, the Court of Appeals correctly decided the procedural matters 14

Conclusion 16

TABLE OF CASES

Adamos v. New York Life Insurance Co., 293 U. S. 386 14

Barnett v. New England Mutual Life, 123 F. (2d) 712 (C. C. A. 5, 1941), reversing 39 F. Supp. 761..... 15

Bowles v. Mutual Benefit Health and Accident Assn., 94 F. (2d) 44 (C. C. A. 4, 1938), 119 A. L. R. 756... 14

Federal Life Insurance Co. v. Ettman, 120 F. (2d) 837, (C. C. A. 8, 1941) 15

Globe Mutual Life Ins. Co. v. Wolff, 95 U. S. 326..... 13

Jones v. United States, 112 F. (2d) 282 (C. C. A. 8, 1940 7

Kaplan v. Manhattan Life Ins. Co., 71 App. D. C. 250, 109 F. (2d) 463 7

Page

New York Life Insurance Co. v. Cumins, 24 F. (2d), 1 (C. C. A. 3, 1938) 7
Phoenix Mutual Life Insurance Co. v. Bailey, 80 U. S. (13 Wall.) 616 14
Phoenix Mutual Life Insurance Co. v. Raddin, 120 U. S. 183 13
Shepard v. United States, 290 U. S. 96 8
Wharton v. Aetna Life Ins. Co., 48 F. (2d) 37 (C. C. A. 8, 1931), Certiorari denied 284 U. S. 621 ..... 7, 10, 11

STATUTES

District of Columbia Code, (1940) Sec. 35-414..... 9

RULES

Rule 13 (a) Federal Rules of Civil Procedure..... 14
Rule 42 Federal Rules of Civil Procedure 14

IN THE

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OCTOBER TERM, 1942.

No. 878.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA, a corporation, *Petitioner*,

v.

JANE SAXE, *Respondent*.

BRIEF OF RESPONDENT JANE SAXE IN OPPOSITION TO PETITION FOR CERTIORARI.

I.

STATEMENT OF THE CASE.

The Petitioner's statement of the case is inaccurate, incomplete and misleading. The established facts are as follows:

The insured, Alexander T. Saxe, applied for a $10,000 life insurance policy with the Petitioner, Prudential Insurance Company of America, in November, 1936 (Tr. 52). The policy was issued in December, 1936 and the beneficiary named in it was the insured's wife, Respondent Jane

Saxe, (Tr. 53) whom insured had married a few months before (Tr. 51). She paid the premiums on the policy until her husband's death (Tr. 55). Toward the end of 1937, the insured became ill, went to the Garfield Hospital on December 29, 1937 and died on January 30, 1938 (Tr. 55). The cause of his death as determined by an autopsy performed at the Garfield Hospital was malignant hypertension of a duration of a year or less (Tr. 79-81). The Petitioner refused to pay the claim of the Respondent as beneficiary and she brought suit in the District Court of the United States for the District of Columbia for the proceeds of the policy. The procedural matters involved will be discussed later.

Petitioner contested the policy on the ground that the insured had made material misrepresentations in the application. The alleged misrepresentations centered in a record of hospitalization at the Beth Israel Hospital, Boston, Massachusetts, which the insured failed to disclose in the application. This hospitalization occurred in January, 1934, almost three years before the application for the policy was made. Petitioner claimed that insured represented that he had not had duodenal ulcer, abnormal blood pressure, dizziness—loss of consciousness and kidney disease and that these representations were both false and material. It relied primarily on the Beth Israel record for proof.

No evidence was offered nor was it seriously urged at the trial that the insured's failure to disclose this was intentional and, in fact, there was evidence that the insured had forgotten the incident (Tr. 363). There was no evidence that the insured knew or had been told what medical findings were made in the Beth Israel record.

The Respondent produced strong evidence to show that the insured was not a bona fide patient during this hos-

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Note. References are either to the transcript of the original record filed herein pursuant to stipulation of the parties (Tr. ——) or to the printed record herein (R. ——).

pitalization and that the health of the insured in the period between the hospitalization and the application was such that the hospitalization could not have been of any consequence. The lack of illness at Beth Israel was demonstrated from the hospital record itself which, while it offered a final diagnosis of duodenal ulcer (Tr. 791), also showed that the insured was entirely sympton free during his entire stay in the hospital (Tr. 814), that he was in no distress (Tr. 796) and that repeated physical examinations were essentially negative (Tr. 789-840). Dr. Pope, on behalf of Respondent, analyzed this record and stated that in his opinion the laboratory data, x-rays and general physical findings in the record proved that the insured did not have duodenal ulcer, nephritis or hypertension (Tr. 82-88). There was uncontradicted testimony by the insured's mother that during his stay in the Beth Israel Hospital he had had subcontractors working with him and conducted business from his hospital room during his entire stay (Tr. 128, 129). It was also established without contradiction that the insured played baseball in the Spring after the hospitalization (Tr. 131, 132). He came to Washington in the Fall of the same year and in the seasons of 1935 and 1936 he pitched an average of two games a week on Government baseball teams. He bowled on bowling teams during the Winters and he played football with the George Washington University football squad in the Fall (Tr. 309, 312, 313). Numerous witnesses testified that during this period he was an active vigorous man and appeared to be in good health (Tr. 305, 311, 303, 308, 299). Dr. Krause, the examining physician for the Petitioner, testified that at the time the insured was examined for the policy in November, 1936, he was in excellent health and that the urine analysis and blood pressure tests made by Dr. Krause during this examination showed no evidence of nephritis or hypertension. Dr. Krause classified him as an excellent risk (Tr. 320-324).

Respondent also showed that the petitioner had waived any right to void the policy on the ground of the Beth Israel hospitalization because it had accepted payment of three premiums during the month after knowledge of the facts had been communicated to its Washington superintendent. The evidence on this was set out in the opinion of the Court of Appeals (R. 192-194).

As to the procedural matters, Jane Saxe verified her complaint for the proceeds of the policy on October 3, 1938 and filed it on October 5, 1938. On the intervening day, October 4, 1938, the Petitioner filed an action against Respondent and Gertrude T. Saxe, mother of the insured, for cancellation of the policy on the ground of fraud. This was designated as Civil Action No. 178 and the action for the proceeds of the policy was designated as Civil Action No. 186.

The Petitioner moved to stay the suit on the policy on the ground that it should have been pleaded as a compulsory counter-claim in the action for cancellation. Mr. Justice Luhring denied this motion on November 10, 1938, counsel having argued that Respondent would be deprived of a jury trial on the fraud issue if she were required to proceed in the cancellation suit. The Petitioner then answered and pleaded by way of defense to the action on the policy, the matters alleged in its complaint for cancellation. Respondent then moved to stay the cancellation action which motion was denied without prejudice to renewal after an answer had been filed. An answer setting up the claim for the proceeds of the policy as a counter-claim was filed by Respondent and the motion to stay the cancellation suit was made again and denied.

At pretrial, Mr. Justice Laws suggested that the two cases be consolidated. The Petitioner again argued in effect that the Respondent's action should be stayed and that the issues which were identical in both suits should be tried by the court without a jury. Mr. Justice Laws pointed out to counsel that no order had been entered on the denial

by Mr. Justice Luhring of the original motion to stay the Respondent's action. Counsel for all parties then conferred with Mr. Justice Luhring in chambers on June 4, 1940 and the matter was fully discussed again after which Mr. Justice Luhring signed an order on June 5, 1940 denying nunc pro tunc the Petitioner's motion to stay which he had decided on November 10, 1938.

On June 6, 1940, Mr. Justice Laws signed a memorandum of pretrial proceedings consolidating the two cases for trial and stating (R. 25):

> " * * * it appearing the complete remedy of both parties is available in a law action, the suggestion or recommendation is made to the trial court that the plaintiffs in the law cause be permitted to open and close the proceedings."

The Petitioner then moved for a rehearing of the original motion to stay the Respondent's suit, Mr. Justice Luhring denied this on October 3, 1940. At the opening of the trial in the District Court the Petitioner moved to have the cancellation suit tried first. This motion was denied by the trial court which adopted the recommendation of the pretrial justice and tried the consolidated case with a jury.

The jury rendered a verdict in favor of the Respondent Jane Saxe on October 10, 1940, and the Petitioner appealed from the judgment entered on such verdict to the United States Court of Appeals for the District of Columbia which affirmed the judgment on January 25, 1943. The majority opinion of the Court of Appeals was written by Mr. Justice Rutledge and Mr. Justice Stephens dissented. The Petitioner now seeks a writ of certiorari from this Honorable Court.

ARGUMENT.

A fundamental misconception of the issues pervades Petitioner's argument. Petitioner's major argument is predicated on the erroneous assumption that the insured was actually hospitalized in the Beth Israel Hospital for duodenal ulcer and other ailments, whereas the substantial proof and verdict demonstrated that this was not the case. A glance at (R. 23 (4) and (5)) will show that the Respondent denied that all of the statements in the Beth Israel record were true and denied that the insured was a bona fide patient. The truth of the Beth Israel record and the question of whether the insured was actually ill while there have been major issues throughout this case and have been found in favor of the Respondent on ample evidence.

It should be borne in mind that in order to defeat the policy the Petitioner was bound to prove either that the insured made false representations with intent to deceive or that such representations were material. No intent to deceive was proven.

Petitioner proved that the insured was "in" a hospital nearly three years before the application. It did not prove that the insured was ill while there nor did it offer any real evidence of other illnesses. Against this the Respondent produced convincing medical testimony that the insured was not really ill at the hospital, uncontradicted testimony that insured conducted his business from the hospital room during his stay and numerous witnesses who proved the good health and unusual athletic activity of the insured during the three years between the hospitalization and the application. The Petitioner's own medical examiner classed the insured as an excellent risk after a thorough examination. Respondent also showed that the insured died over 14 months from the date of the application of a disease which existed for a year or less. On this state of evidence, the matter was clearly for the jury and the Court of Ap-

peals was correct in sustaining the judgment in favor of the Respondent on the jury's finding.

Wharton v. *Aetna Life Ins. Co.*, 48 F. (2nd) 37 (C. C. A. 8, 1931) cert. denied 284 U. S. 621.
N. Y. Life Ins. Co. v. *Cumins*, 24 F. (2nd) 1 (C. C. A. 3rd, 1938).
Kaplan v. *Manhattan Life Ins. Co.*, 71 App. D. C. 250 109 F. (2nd) 463 (Ct. App. D. C. 1939).
Jones v. *U. S.*, 112 F. (2nd) 282 (C. C. A. 8th, 1940).

This phase of the case was aptly summarized by the trial court who remarked to Petitioner's counsel out of the presence of the jury, "I don't believe that they [Petitioner] would have paid the slightest attention to that sickness in the hospital". (Tr. 631.) The other phases of the case, waiver and procedure, will be discussed in the consideration of Petitioner's brief following.

AS TO POINT A OF PETITIONER'S BRIEF.

Petitioner argues in Point A of its brief that the Court of Appeals injected a new issue into the case not considered at the trial and reached its decision on that issue on evidence admitted for a limited purpose. This argument is based on a misinterpretation of the court's language and the basic misconception of the issues explained before. It also places a false emphasis on the court's use of the word "fictitious" to characterize the Beth Israel incident.

Petitioner maintains that the truth of the Beth Israel record was not in issue at the trial and that, therefore, it was deprived of the right to produce evidence to meet this issue. It is perfectly obvious from the record that Petitioner knew long before the trial that the Respondent had denied the truth of the Beth Israel record (R. 23 (4)) and denied that the insured was a bona fide patient (R. 23 (5)). Petitioner had ample opportunity to prepare for and meet this issue at the trial if it could. The Court of Appeals properly recognized this issue.

In *Shepard* v. *U. S.*, 290 U. S. 96, on which Petitioner relies, a Dr. Shepard was on trial for the murder of his wife. The wife's statement to the effect that her husband had poisoned her was admitted by the trial court as a dying declaration although she did not die until some time later. The Circuit Court of Appeals ruled that while the statement was inadmissable as a dying declaration it could have been admitted for the limited purpose of showing her state of mind in rebuttal of other declarations which indicated a suicidal intent. This court held that the appellate court could not take inadmissable evidence generally introduced and sustain its admission on a limited ground because the trial court would have had to explain the limitation to the jury to define the bounds within which the statement could be used as evidence. It further held that the balance of interest was clearly against admitting the evidence on any theory.

In the present case, the Court of Appeals has not taken any such action. The court gave a clear explanation of the issue on page 4 of the opinion (R. 191) which was:

> "There is no dispute that the insured was 'in' the hospital for the two weeks. But there is a square clash on the reason and purpose of his being there and the consequences for the insurer's liability. The evidence, and the conflict, are crucial both for the issues concerning the alleged misrepresentations and their effects and also for the claimed waiver."

The case did not go to the jury solely on the evidence referred to by the Petitioner but on the substantial evidence set forth in the opinion in great detail. On this score the court said (R. 195):

> "Taking account of all the evidence in her behalf, we cannot regard it as inherently incredible, and for that reason improper for submission to the jury."

The Court of Appeals committed no error and no question is presented for review of the decision on this point.

AS TO POINT B OF PETITIONER'S BRIEF.

The D. C. statute (Act of Congress of June 19, 1934, 48 Stat. 1133 c. 672, par. 15, ch. II) (District of Columbia Code (1940) sec. 35-414) provides:

> "The falsity of a statement in the application for any policy of insurance shall not bar the right to recovery thereunder unless such false statement was made with intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the company."

Petitioner claims that in interpreting this statute, the Court of Appeals gave no effect to the provision thereof which bars recovery if a false statement materially effects the acceptance of the risk. The Court of Appeals made no such ruling as a reading of the opinion will disclose. It did hold that there was a substantial evidentiary conflict on the falsity and materiality of the insured's representations and that the conflict was resolved by the jury in favor of the Respondent on sufficient evidence.

With a conflict in evidence on the material facts, the case was properly submitted to the jury under the cases cited on page 7 supra.

There is a sharp distinction between the cases in which there is no conflict in the material facts and the ones in which there is a conflict. The Petitioner relies on the former line of cases but they are not applicable to the case at bar because of the substantial conflict in evidence herein. In practically all of the cases cited by the Petitioner, the insured concealed a very material matter. For example, in *Mutual Life* v. *Hilton-Green*, the insured concealed a previous unsuccessful application for insurance as well as prior consultations with doctors; in *Kavakos* v. *Equitable Life*, the insured concealed 80 consultations with doctors over a short period prior to the application; in *Columbia National Insurance Co.* v. *Rogers*, the insured concealed a rejected application for insurance within 10 months prior to the application in question; in *Mutual Life* v. *Hurni*

Packing Co., the insured concealed numerous consultations with doctors, three months rest at a health resort and a course of serum injections; in *Aetna Life Insurance Co.* v. *Perron*, the insured concealed a complicated glandular ailment and numerous consultations with physicians and hospitalization for diagnosis; in *Lawrence* v. *Connecticut Mutual Life*, the insured concealed numerous consultations with physicians, sojourn in a hospital, operation on his neck, deep therapy and statements of his doctor and surgeon that he had sarcoma; in *Home Life Insurance* v. *Madere*, the insured concealed an operation for an infected cyst and other illnesses; in *New York Life* v. *McCarthy*, the insured concealed the fact that he had consulted doctors frequently in the three years prior to the application for a growth near his heart; in *Fountain and Harrington* v. *Mutual Life*, the insured concealed appendicitis pains for which an operation was required a couple of months after the application; in *New York Life* v. *Drooker*, the insured concealed consultations with doctor, periodic urine analyses over 18 months and a restricted diet; in *Equitable Life* v. *Carver*, the insured concealed sleeping sickness which had impaired his right side and rejections of two prior applications for insurance.

The facts in the present case are clearly under the rule of *Wharton* v. *Aetna Life Insurance Co. supra*, page 7. There the court said (p. 43):

> "The jury might, under the evidence, have believed that the insured, in good faith believed that except for the appendicitis all other ailments for which he had consulted a physician were of a trivial character. To void this policy on the ground of false representation, the answer must not only have been untrue but it must have been with reference to a material matter and must have been knowingly false. When it is doubtful whether the misrepresentation was material or not, the question of materiality must be submitted to the jury."

The Wharton case was before this court on a petition for certiorari which was denied in 284 U. S. 621. In that pro-

ceeding, the Respondent's brief set out a very thorough analysis of the federal cases on the point and we respectfully direct the court's attention to that discussion (*Wharton* v. *Aetna Life Insurance Co.*, Docket No. 103, October Term 1931, Respondent's Brief pp. 22 et seq.)

Under the Wharton case, no question is presented for review by this court.

AS TO POINT C OF PETITIONER'S BRIEF.

Petitioner contends that under the opinion it is necessary to establish that the insured had the disease for which he was hospitalized and that it was the cause of death or existed when death occurred to defeat the policy. This contention goes far beyond the opinion and fails to comprehend the court's actual decision.

The statute requires misrepresentations to be either made with intent to deceive or material to the "acceptance of the risk" or "hazard assumed" by the company. The court found that the insured's statements were not made with intent to deceive and that, due to the conflict in evidence on materiality, the question of materiality was for the jury and found in favor of the Respondent. It then discussed the alternate "hazard assumed" phrase of the statute. In passing, the court stated (R. 201) that a misstatement to be material to the "hazard assumed" must be shown in some way to have affected it or contributed to the loss and in a substantial manner. This is a perfectly correct statement of law but the petitioner's argument fails to recognize the distinction between "hazard assumed" and "acceptance of the risk" and the separate treatment of the two phrases by the Court of Appeals.

Hesselberg v. *Aetna Life Insurance Co.* cited by the Petitioner is not applicable because of the materiality of the concealment. There the insured represented that he had not consulted a doctor or suffered any injuries. The undisputed facts were that 8 days before the representations, the insured had been in an automobile accident, and con-

sulted a doctor for his injuries and was starting a law suit in which he subsequently recovered $25,000 for the injuries.

AS TO POINT D OF PETITIONER'S BRIEF.

Petitioner complains that the court's decision on waiver was contrary to the decisions of this court. Here again this argument is based on the unestablished premise that the insured had duodenal ulcer and other ailments when he was in the Beth Israel hospital. Actually, the insured told the Petitioner all he knew concerning the hospitalization. No more would have been required of him in answering the application. A full month before the insured died, the information was communicated to the Washington Superintendent of the Petitioner, a man who admittedly had authority to solicit risks and accept payments of premiums and who was held out by his license from the Superintendent of Insurance of the District of Columbia as a general agent of the Petitioner. The Petitioner accepted three premiums after this information had been communicated to its local superintendent and took no action until after the insured died, a month later. It should be noted that the Court of Appeals rested its decision on a narrow ground. The actual basis was (R. 205):

> "In this case Brine was not without authority to receive information on the company's behalf. He was authorized to forward complaints and controversies concerning matters affecting policies to the home office. It was his duty to do this. When he failed, it was a breach of his duty to the company, and at the same time of its duty to the insured and to the beneficiary. Under the circumstances, in which the knowledge was communicated, the insurer owed them the obligation to act, to do so promptly, and in such a manner as not to lull them into false security, so that the loss would fall and foreclose any opportunity to secure further action to establish, preserve or settle their rights. If more was needed than was done, the insurer should have informed the insured or his representative what it was. It cannot now shift to appellee's shoulders the burden

of Brine's breach of duty to itself, or of its own duty to the insured. Consequently when Brine received the knowledge and failed to communicate it promptly to his principal, that is, the home office, it became charged with notice of the existence of the grounds for forfeiture. When, in addition, it received the premiums and allowed the matter to rest for nearly a month, and until the loss had fallen, without returning them or doing anything further about the matter, the waiver was effectually completed. We have purposely put the matter thus narrowly, because on these facts it is not necessary to decide whether Brine's receipt of the information and the premiums, without more, would have been sufficient as a waiver."

This holding is perfectly in accord with principles laid down by this court. In *Globe Mutual Life Insurance Co.* v. *Wolff*, 95 U. S. 326, 24L Ed. 387, this Court said, (p. 332)

> "It is true that where an agent is charged with the collection of premiums on policies it will be presumed that he informs the Company of any circumstances coming to his knowledge affecting its liability; and, if subsequently the premiums are received by the Company without objection, any forfeiture incurred will be presumed to be waived."

And in *Phoenix Mutual Life Insurance Company* v. *Raddin*, 120 U. S. 183, this Court said, (p. 196)

> "It follows that the only question upon the instructions of the court to the jury which is open to the defendant on this bill of exceptions is whether if insurers accept payment of a premium after they know that there has been a breach of a condition of the policy, their acceptance of the premium is a waiver of the right to avoid the policy for that breach. Upon principle and authority there can be no doubt that it is. To hold otherwise would be to maintain that the contract of insurance requires good faith of the assured only, and not of the insurers, and to permit insurers, knowing all the facts, to continue to receive new benefits from the contract while they decline to bear its burdens."

See also *Bowles* v. *Mutual Benefit Health & Accident Association*, 99 F. (2d) 44, 119 A. L. R. 756 (C. C. A. 4th, 1938).

No question is presented for review on this point.

AS TO POINT E OF PETITIONER'S BRIEF.

The procedural steps herein are set forth in the Statement of the Case, supra, pp. 4, 5. It should be borne in mind that this action was instituted two weeks after the adoption of the new rules. Respondent throughout the entire proceedings insisted on her right to a jury trial under *Phoenix Mutual Life Insurance Company* v. *Bailey*, 80 U. S. (13 Wall) 616 and *Adamos* v. *New York Life Insurance Company*, 293 U. S. 386.

Petitioner has not stated the true ratio decidendi of the Court of Appeals on this point. On page 19 of the opinion, the court said (R. 206):

> "It remains to consider the alleged procedural errors. There was no error in consolidating the causes for trial or refusing to try the so-called equitable issues separately and before proceeding with the trial at law. The insurer's suit to cancel the policy was filed the day before Jane Saxe instituted her suit to recover on the policy, in which Gertrude Saxe intervened. The grounds asserted for cancellation were the same as those relied upon for defense in the suit to recover on the policy. The parties were the same. It was clearly proper therefore for the court to consolidate the causes and submit the entire matter to jury trial."

The court then discussed the various contentions urged by the parties, including the Petitioner's arguments on Rule 13a, and concluded (R 208—209):

> "Finally, Rule 42 confers on the District Court broad discretionary powers for consolidation of actions 'involving a common question of law or fact.' Rule 13 (a) should be construed in harmony with it. We need not decide, therefore, whether appellee had a right to jury trial, in these circumstances, or whether it would

have been an abuse of discretion to deny it. The court's discretion was exercised in her favor, and there clearly was no abuse in so exercising it. This applies both to the consolidation of the causes and to the denial of the motions, after consolidation, for the separate and prior trial of the so-called equitable issues."

There are two other Circuit Court cases of interest on this point. In *Barnett* v. *New England Mutual Life Insurance,* 123 F (2d) 712, (C.C.A. 5th, 1941), which reversed the lower court decision relied on by Petitioner, the insured died within the contestable period. The insurer filed an action for cancellation in January, 1939. In September, 1939, the beneficiary sued on the policies. The insurer obtained a stay on this action pending disposition of its suit for cancellation. The beneficiary answered the cancellation suit and counterclaimed for the proceeds of the policy. The cause was tried before a jury but at the close of the evidence the court dismissed the jury, treated the case as one of equitable cognizance, and entered a decree of cancellation. The Circuit Court of Appeals held that it was error to treat the action as of a purely equitable nature, that the fraud defense was fully available to the insurer as a defense to any action on the policies and that there was no occasion for granting equitable relief.

And in *Federal Life Insurance Co.* v. *Ettman,* 120 F (2d) 837, (C.C.A. 8th, 1941), the insurer brought suit for cancellation of a disability policy. Eleven days later the insured brought suit for disability benefits and moved to dismiss the insurer's suit for cancellation. The motion was granted, the insurer appealed and the Circuit Court of Appeals sustained the dismissal of the cancellation suit on the ground that the insurer's remedy was adequate in the law action.

The holding of the Court of Appeals herein is in harmony with these decisions under the Federal Rules of Civil Procedure and with the decisions of this court in the Bailey and Adamos cases (supra p. 14). No question is presented for review.

CONCLUSION.

The Petitioner, in order to defeat recovery on the policy, was required to prove that the insured made false statements either with intent to deceive or that materially affected the acceptance of the risk or hazard assumed by the Petitioner. It conspicuously failed to do this. On the other hand, the Respondent showed by convincing medical testimony that the insured was not ill at the Beth Israel Hospital; that he enjoyed excellent health and demonstrated unusual athletic activity for nearly three years before the policy was issued; and that the facts of the hospitalization were disclosed to the insurer's local superintendent and thereafter the insurer accepted payment of three premiums. The jury's verdict in favor of Respondent and the judgment thereon were found on sufficient evidence. No error was made in permitting a jury trial of the issues. The Court of Appeals has followed the decisions of this court applicable to the facts, its decision is entirely correct and we respectfully submit that no question is presented for review. The petition for a writ of certiorari should be denied.

Respectfully submitted:

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